NDP024:
PROSTATE ABSCESS IN A PERITONEAL DIALYSIS PATIENT

Ping-Ju Tsai [1], Cheng-Chen Su [1], Chung-Sung Shen [1], Shih-Ya Hung [1], Yi-Chun Liu [2]. [1] *Division of Urology, Yuan's General Hospital, Kaohsiung, Taiwan;* [2] *Division of Nephrology, Yuan's General Hospital, Kaohsiung, Taiwan*

Prostate abscess is an uncommon condition of infective urinary tract disease. Predisposing factors for prostate abscess included acute bacterial prostatitis, urethral catheterization, diabetic mellitus, chronic kidney disease, cirrhosis and immunocompromised patients. The prostate abscesses were attributed to gonococcus, Escherichia coli, Staphylococcus aureus, and Klebsiella pneumoniae. We can make the diagnosis with transrectal ultrasound and abdominal CT scan. Treatments of prostate abscess were attributed to parental broad-spectrum antibiotics administration and abscess drainage. The methods of drainage included transrectal aspiration and transurethral (TUR) incision of prostate.
We presented that a 60-year-old male has hypertension, diabetes mellitus, coronary artery disease, cerebrovascular accident with left hemiparesis, bilateral blow-knee amputation, and end stage renal disease with peritoneal dialysis. He called for help at emergency room due to fever, poor appetite, and vomiting. Abdominal CT scan revealed loculated fluid and air collection in the prostate and seminal vesicles. We performed TUR drainage and urethral Foley indwelling with 24 hours irrigation. Prostate abscess pus culture showed Escherichia coli. After 2 days, we removed the drainage Foley and he was discharged. Unfortunately, he recalled for help at emergency room due to cloudy peritoneal dialysis fluid and sepsis. Peritoneal fluid culture revealed Escherichia coli. We suspected prostate abscess related continuous ambulatory peritoneal dialysis (CAPD). After removal of peritoneal dialysis tube and antibiotics therapy, his conditions improved. At last, he was under stable conditions and received regular hemodialysis at outpatient department of nephrology.

Other

NDP025:
UNILATERAL DOUBLE URETER WITH URETHROCELE MASQUERADING URETEROCELE — CASE REPORT

Shih-Chang Fuh [1], Meng-Lin Chang [2], Shao-Yu Lin [2]. [1] *Department of Urology, Taoyuan General Hospital, Taoyuan, Taiwan;* [2] *Department of Urology, Taipei Medical University Hospital, Taipei, Taiwan*

Background: Ureterocele is a cystic out-pouching of the distal ureter into the urinary bladder, and sometimes it may have ectopic insertion into urethra with associated duplicated collecting system.
Urethrocele is a focal out-pouching of the urethra. Urethrocele and ureterocele share some same symptoms, such as urinary incontinence, urinary frequency and recurrent infection. It is difficult to differentiate urethrocele from ureterocele by symptom. The gold standard of diagnosis is image study. We present a case of urethrocele with ureteral duplication, mimicking the presentation of ureterocele in both symptoms and image study.
Case Report: A 38-year-old woman presented to our department with recurrent urinary tract infection and urinary incontinence. She had multiple clinics visited with different diagnosis, such as uterine prolapse, bladder prolapse or ectopic ureterocele. Pelvic exam revealed a protruding, soft mass over anterior vaginal wall. Urinanalysis showed mild microscopic hematuria. Intravenous pyelography disclosed duplication of left collecting system. Cystourethroscopy showed small opening over urethra. MRI revealed fluid acumination over peri-urethral lesion. Due to the annoying urine leakage and recurrent infection episode, surgical intervention of drainage was first applied. Then excision operation was then arranged. After surgical treatment, no more urinary incontinence was reported by the patient.
Discussion: Several theories have been proposed to explain the etiology of female urethral ureterocele. Most urethrocele are acquired. Potential theorized causes of acquired urethrocele include vaginal birth trauma, urethroscopy, urethrotomy, and various open surgical procedures. However, most widely accepted theory implicates repeated infections of the periurethral glands with subsequent obstruction eventually evolving into urethrocele. Congenital urethrocele is rare. Due to the embryonic origin of distal urethra and ureter, congenital urethrocele have been postulated to arise from congenital dilatation of periurethral cysts, association with blind ending ureters. Thus, congenital urethrocele may be difficult to be differentiated from ureterocele, physician should be alerted.

NDP026:
SINGLE MASSIVE URETER POLYP CAUSING URETER INTUSSUSCEPTION: A CASE REPORT AND LITERATURE REVIEW

Pao-Hwa Chen, Chun-Chi Chen, Bai-Fu Wang, Jensen Lin, Heng-Chieh Chiang, Meng-Yi Yan, Chang-Pao Chang, Sheng-Hsien Huang, Kuo-Hsuan Huang, Hung-Jen Shih, Jian-Xiang Zhang, Jian-ting Chen. *Divisions of Urology, Department of Surgery, Changhua Christian Hospital, Changhua, Taiwan*

Introduction: Ureteral intussusception is a rare complication caused by intra-ureteral lesions (i.e. ureteral calculi or ureteral mass). Here, we present a case of ureteral intussusception cause by single massive ureteral polyp.
Case presentation: This 44 years old man first presented at our ER symptoms of renal colicky pain and painless gross hematuria. After initial survey, IVP showed middle ureteral stricture without distal ureter enhancement. Due to symptoms of painless gross hematuria, cystoscopy and ureteroscopy was ordered. Intra-operative images showed huge polyp at lower 1/3 ureter and uretero-vesical junction. Biopsy was obtained and obstruction was relieved with electrocautery. Due to size of the polyp, malignancy was first suspected and CT scan was ordered and intussusception of middle ureter was noted. Biopsy later revealed to be fibroepithelial polyp of ureter.
Conclusion and discussion: Intussusception of ureter is a rare complication of intra-ureteral lesion with the typical presentation of flank colicky pain, hematuria and hydroureter. Most of the prior reported cases of ureteral intussusceptions were benign in origin, but the first case of intussusceptions caused by ureteral TCC was reported on 1987. Ever since, half of the reported cases of intussusceptions are related to intra-ureteral malignancy. Therefore, we also keep malignancy in our minds in cases with images of intussusceptions and the typical symptoms until proven otherwise with biopsy.

NDP027:
A CASE OF GIANT RENAL CYST WITH MIGRATING KIDNEY: A CASE REPORT AND REVIEW OF LITERATURE

Chou Chen-wei, Leonard S. Chuech, Tu Yuan-po, Hsu Fu-shun. *Department of Urology, New Taipei City Hospital, New Taipei City, Taiwan*

Introduction: Simple renal cysts are among the most common cystic lesions of the kidney. Most benign renal cysts are asymptomatic and require only observation. However, rarely these cysts may become huge in size and result in significant symptoms. Cases of huge renal cysts have been rarely reported. Thus, we reported a 74-year-old female who presented with repeat urinary tract infection and massive abdominal distention. After control of infection, surgical intervention with hand-assisted laparoscopic renal cyst unroofing was performed.
Case report: A 74-year-old female visited emergent department due to right flank pain and fever for days. Initially, acute pyelonephritis was suspected because of pyuria. She was then admitted to urologic department for further management. On physical examination, right flank knocking and massive abdominal distention were noted. The distended abdomen was soft and elastic texture.
A CT scan was arranged and revealed a huge well-defined cystic lesion occupying almost two-third of abdominal cavity, displacing left kidney to right side. The cystic lesion measured 32 x 24 cm in size. Surgical intervention was advised in view of the significant cyst in size and internal organ compression.